

**MARICOPA INTEGRATED HEALTH SYSTEMS HEALTH PLANS
PROTOCOL**

SUBJECT: Sleep Study (Polysomnogram)	Protocol #: PA P217.02 Protocol Pages: 2 Attachments: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Initial Effective Date: June 1999 Latest Review Date: May 2002
APPLIES TO: MHP <input checked="" type="checkbox"/> MLTCP <input checked="" type="checkbox"/> MSSP <input checked="" type="checkbox"/> HEALTHSELECT <input checked="" type="checkbox"/>	
MIHS HEALTH PLANS APPROVALS: Director, Medical Management: _____ Date: _____ Medical Director: _____ Date: _____	

PURPOSE: The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to Sleep Study (Polysomnogram).

PROTOCOL:

- A. Sleep Study (Polysomnogram)
CPT: 95806-95807
LOS: OP
- B. Overview
Disorders of sleep are common medical conditions affecting up to 7 percent of the population. These disorders have diverse etiologies and consequences. Some sleep disorders can have a significant adverse impact on the patient's quality of life and wellbeing. The proper assessment of sleep disorders must begin with a thoroughly documented history and physical examination. Questions about the use of alcohol and/or other sedating substances must be asked and documented. The definitive study to evaluate sleep disorders is the polysomnogram (PSG). This protocol provides guidelines for the authorization for the PSG for the prior authorization specialist. Approval requires a review by a prior authorization nurse.
- C. The prior-authorization specialist may approve a PSG if the following criteria are met:
 1. A thorough history and physical examination has been documented and supplied with the PSG request – **AND ONE OF THE FOLLOWING, 2 Through 6 BELOW**–
 2. Snoring is witnessed to be present during sleep by another person *in the absence of the influence of alcohol or sedating substances/drugs*, **PLUS** at least one (1) of the following:
 - a) Witnessed apneic periods with sleep –**OR**—
 - b) Unexplained excessive daytime sleepiness over the course of several months that impairs normal function *in the absence of the influence of alcohol or sedating substances/drugs*. Typical functional impairment associated with excessive daytime sleepiness includes the following:
 - falling asleep while driving a car or while at work
 - personality changes
 - recurrent morning headaches
 3. Hypertension **WITH** one of the following signs of disordered sleep:

- a) hypnagogic hallucinations
 - b) enuresis
 - c) violent sleep or awakening behavior
 - d) sleep paralysis
 - e) sleep walking or automatic motor motion--**OR**—
4. Documented arrhythmias --**OR**—
5. Witnessed nocturnal seizures --**OR**—
6. To determine optimal CPAP settings in patients with known obstructive sleep apnea --**OR**—
7. In children, to obtain growth hormone sampling **IF**
- a) Associated with puberty before age 10 --**OR**—
 - b) Associated with a documented decline in normal growth rate, generally less than 4.5 cm/year, without known cause
- D. This criteria is a guideline for prior authorization and does not represent a standard of practice or care.
- E. This protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage guidelines under the specific plan.
- F. If requirements are not met, Medical Director review is required.

ATTACHMENT:

- A. Sleep Study Questionnaire

2 Pages

Total Attachment Pages 2

MIHS Health Plans reserves the right to change the protocol for administrative or medical reasons without notification to external entities. This protocol is not intended to be utilized as a basis for a claim submission.

Patient _____

Date _____

Height _____ Weight _____

CC: _____

Sleep Apnea Symptoms

Snoring? YES ☐ NO ☐ UNKNOWN ☐
Witnessed apneas? YES ☐ NO ☐ UNKNOWN ☐
Patient report? YES ☐ NO ☐ Family confirmation? YES ☐ NO ☐
Hypersomnolence? YES ☐ NO ☐ UNKNOWN ☐
Epworth Sleepiness Scale Score _____
While driving or falling asleep at a traffic light? YES ☐ NO ☐
Other significant impairment secondary to sleepiness? _____

Associated Respiratory Conditions

COPD/Asthma YES ☐ NO ☐ Degree of control? _____
Other: YES ☐ NO ☐ Degree of control? _____
Does patient use nocturnal oxygen? YES ☐ NO ☐ Flow rate? _____
PFTs Date _____ FEV _____ FVC _____ Not done _____

Other Sleep-Related Symptoms

Restless legs or periodic limb movements of sleep? YES ☐ NO ☐
Insomnia? Early ☐ Middle ☐ Late ☐ Non-restorative sleep ☐
Sleepwalking or other sleep behaviors?
Describe _____
Other? _____

Other Medical Conditions

Thyroid Disease? YES ☐ NO ☐ Degree of control? _____

Medication List

Potential impact on sleep symptoms? YES ☐ NO ☐
Adjustments needed prior to sleep study? YES ☐ NO ☐

Comments

Signature

Signature

SLEEP QUESTIONNAIRE
(Epworth Sleepiness Scale)

Patient's Name _____ **Date** _____

How likely is it that you will fall asleep in the following situations? Please circle a number for each situation.

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Sitting and reading	0	1	2	3
Watching t.v.	0	1	2	3
Sitting in a public place, like a waiting room	0	1	2	3
Riding in a car for one (1) hour	0	1	2	3
Lying down to rest	0	1	2	3
Sitting & talking	0	1	2	3
Sitting after lunch without alcohol	0	1	2	3
In a car while stopped in traffic	0	1	2	3

Total Score _____